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ABSTRACT

Workshop sessions focusing on the issue of collaboration between health care services and day care services are documented in this report. The keynote address elaborates the thesis that day care programs should provide therapeutic care, particularly primary health care for ill children and staff, and assistance in obtaining secondary care. In subsequent panel discussions a college level course on health in early childhood education is described, a day care center's policy for providing health care is outlined, the role of the consulting physician is discussed, and ways of utilizing a family or pediatric nurse practitioner are suggested. Small group presentations focused on dramatizing a problematic interaction between day care and health professionals, how to recognize and respond appropriately to developmental lag, how to use a medical record, and legal implications of health care for children in day care, including parental consent and child neglect and abuse. A report of a small group discussion provides a list of local resources for and barriers to providing health care services in day care centers. The concluding address briefly describes concerns and actions of the North Carolina Department of Human Resources in meeting the health needs of children in day care. (Author/RH)

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HEALTH OF CHILDREN IN DAY CARE

VOLUME I

A REGIONAL HEALTH CARE / DAY CARE WORKSHOP

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Content report of a 1978 workshop sponsored in North Carolina by:

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Why This Publication?

Workshops have a way of happening, having an effect on the participants, and then fading from memory. This obscurity, lack of documentation, lack of measurement is appropriate for most workshops--after all, they are the most common of professional renewal activities and don't deserve more attention.

Greater attention has been focused on this workshop not because it was notable in method or in resources, but because it concerns an issue of critical and current importance: health care/day care collaboration. Health care services and day care services need increasingly to work together if certain children are to be well served. People are ready to respond to the need for collaboration not only in North Carolina, but around the nation. This workshop has been documented as a small contribution to the process through which professionals will grapple with this challenge.

The report documents the workshop through a record of the workshop sessions (Volume I) and a record of the process by which the workshop was developed and evaluated (Volume II). Transcripts are included in the first volume; data and evaluation instruments are included in the second. Hopefully, this information will be a useful professional resource to individuals and groups wishing to hold similar interdisciplinary workshops or wishing simply to stimulate further interaction and collaboration in the local setting.

HEALTH OF CHILDREN IN DAY CARE, Volume I

Joseph Sparling, Beverly Mulvihill, and Richard Clifford, Editors

Frank Porter Graham Child Development Center, UNC-CH

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HEALTHY DAY CARE

Ann DeHuff Peters
University of California at La Jolla

I would like to start out with two definitions...The first is the World Health Organization definition of health: "Health is a state of complete physical, social and emotional well-being and not merely the absence of disease or infirmity." The second is the definition of day care, which to me is a family support service, and which includes all types of care of children: informal arrangements, family day homes, group care, part-time care and so on--any way in which a family is being assisted with the complex task of child rearing.

Day care services should be comprehensive. In my opinion any day care program or community organization for day care must include health services an an integral part of the package. This should begin with preventive health services such as health maintenance, nutrition, immunizations, environmental control, and the promotion of mental health. We often forget mental health and talk of physical health only. We cannot separate them any more than we can separate family support services, which is what day care really is, and health care. A day care program also should include therapeutic care, particularly provision of primary health care for ill children and for staff, and assistance in obtaining secondary care when that is indicated.

My main interest when I was involved in the planning of the Frank Porter Graham Child Development Center was in providing comprehensive health care to children and providing it when they needed it, not when and where we as professionals thought they should have it. The Center began with health care as an integral part of the program.

We provided complete health care for the children aged six weeks to five years. The first year, after experiencing real problems in using the pediatric services at Memorial Hospital, I developed a contract with one of the town pediatricians. We had two nurses, one an excellent professional who became head of the operations staff. Because we were taking young infants, and allowing all children to come every day whether sick or well, I felt we needed the protection of well-trained health professionals to avoid serious risks of epidemic infection. Due in large part to her skill in educating the rest of us, we never did have epidemic problems. She and I shared the responsibility of teaching the staff the essential preventative techniques, such as disposal of diapers, handwashing, and keeping the diaper-changing area clean. The other nurse was a public health nurse who went out and visited the familes at home and provided us with a tie-together of all the things that were happening to the children in their various environments. So, we went along for a year with the help

of the town pediatrician, and I took care of the children during the week. At the end of the year, our own full-time pediatrician came. He was doing research and supervising the nursing staff, as well as giving direct care. We sent our public health nurse to be educated as a nurse practitioner and she took over most of the direct care of the children. When I left in 1969, it was quite apparent that not only was the system working, but that it was working extremely well. The parents were very much involved. The kids were being well cared for. The care-giving staff had learned what to do. We didn't push the panic button every time a child ran a slight fever. We didn't even isolate sick children.

One of the studies which was reported in the March 1972 issue of Pediatrics, called "Respiratory Disease in Group Day Care," by Frank Loda and the group at the Laboratory of Infectious Diseases of the School of Medicine was a very nicely put together statistical study. It included our children, a group of comparison children the same age, and children cared for by a pediatric private practice group in Chapel Hill. There was no significant difference in the incidence of febrile illness in the ghree groups of children. They all were sick fairly often because all little children get sick. They had the same "bugs," judging by the studies of the antibody titers, and they all had the orgamisms or the diseases that were current in the community in that particular year.

I am still convinced that you must provide total care for the children and for the familes. The busy mother or the busy father or the busy other relatives, not only don't have time but often don't have the money to go to a hospital emergency room which is often the only thing open in the evening. Rather than recognizing the emergency room as the primary care medical source for many many familes, we must reverse that trend and provide care in more accessible and less expensive settings.

I would like to begin to list some of the things that I think one must think about in planning for healthy day care. First of all, healthy day care beings with, and urgently depends upon, careful selection of the adults and teenagers who will provide the direct care of the children. What do you look for in terms of staff selection? The quality of staff is an important part of the health of the entire program. You look for someone who really likes children; someone who really likes himself or herself -- in other words has a good self image, a sense of self-worth; someone who can share the children with the parents, who recognizes that this is a collaborative endeavor and who respects the parents. You look for someone who can learn; someone who has a sense of humor; someone who can set limits; someone who can be flexible and can individualize care; and lastly, someone who has the physical and mental stamina to function through the long day. Let's face it; the care of little childre-, especially if one does a good job, is exhausting.

Now what do you do for your staff to promote good health -- physical, social and emotional? First of all, you pay them adequately. Secondly, you give them proper fringe benefits, which include paid vacations, sick-leave, and educational leave. Thirdly, you insist that they take a lunch break away from the children or get away for at least part of the day. Fourthly, you have regular staff meetings (or what I call "squawk times") for ventilating feelings, for exchange of ideas, and for planning ahead.

Now I want to give a word about an always touchy subject,and that is the question of pre-employment physicals for staff people. I used to say it really wasn't important except for a tuberculin test and blood pressure check. But I have finally been convinced by some of my colleagues that a pre-employment physical is probably okay because it gives you a base line for Workmen's Compensation, and that is really the main reason. The problem with a physical examination at any time and at any age is that it only tells you what's going on at that point in time. It does not give you anything in the way of predictive value unless the individual has never been examined and has never been in a setting where anyone has looked at him or observed his behavior. What I am saying is that you really don't need to spend a lot of money in having all of your employees go through a medical examination, but you probably will have to do it if you want to be covered by Workmen's Compensation. You need to have some kind of base line, so that's all I am going to say about that.

Now what about the environment? Providing a healthy environment depends a great deal upon the ages of the children. There are many obvious things that apply across the board such as safe water, adequate sewage and trash disposal, fences and safety gates, buildings in good repair, ramps instead of or in addition to stairs, sturdy toys and equipment since splintery plastics and sharp edges can be lethal in some instances. We also should think about water fountains at the child's level, medicines and cleaning supplies locked up -- all of these you can read in almost any book. If infants and toddlers are in a day care setting, other safe guards are, of course, important. Diaper changing areas for infants have to be clean. Diaper disposal in closed hampers, with frequent diaper service pickup is a must. I personally discourage the use of disposable diapers because of the disposal problem, and because paper diapers often cause diaper rash. You must look for safe cribs with the slats close enough together so that the baby cannot get his head through. You have to be careful about electric cords, and you should also be careful about them for older children and staff. You have to be very careful about the kinds of hazards for staff, such as slippery "throw" rugs. Sometimes the children manage better with such hazards than the staff does. You cannot make an environment completely safe unless you remove everything that makes life fun and interesting, so you have to use common sense, but it pays to look around to see what kinds of things can be done that will make life easier. I am very pleased that plug-in caps are now available

to cover electric wall sockets. That sort of thing is very simple, very cheap, and very important.

Now what about the families we serve? Well, parents look to day care givers as experts whether we like it or not. They want a lot of help and reassurance, but they also want to know that they are still the important figures in the child's life. I went one day to visit a Student Day Care Center in Los Angeles. The director's office was a former bedroom that was on the front of the house. She told me that she spent as much time as she could in that office at the time the parents were coming to get the children, because she could see them coming up the stairs, could see the expressions on their faces, and could tell whether they were walking up with jaunty steps or dragging up worn out. This told her which ones to beckon in and say "come in and sit down a minute." She was doing more for the mental health of those families than any number of high priced health professionals. One thing I want to say -- and I am not going to make very many pronouncements today -- that is never, but never condescend to a parent, no matter how concerned you may feel. Positive re-enforcement always works better than negative and you can always find something to compliment a person about. Remember that day care is a partnership with the parent, and that your interaction with the parent can contribute very significantly to that family's mental health.

Now I am going to spend a very brief period talking about the health of children. I have already told you my bias, which is that we should take care of the whole child whether he/she is sick or not. One of the ways you do this is to help support the common sense that most people develop as they are associated with children. We physicians have spent years and years tearing down the confidence of everybody about doing things for themselves and recognizing the value of certain common sense remedies; such things as a cool bath for a child with fever, much more important than Tylenol which is expensive and not always available, of plain salt water washes for sore eyes and runny noses, and a simple liquid diet for the child with diarrhea. An observant parent -- and if you give parents a chance they will be observant -- will tell you what they see, and if you give your day care staff a chance, they too will be observant. Both of them can learn to act wisely and simply to remedy many symptoms. We need somehow to begin to build up peoples' self-confidence in taking care of the common garden variety illness. We really need to spend our money in that direction rather than in a lot of high priced medical care.

Now what about children's pre-entrance physical examinations? I think a pre-entrance physical is ridiculous and I have said this in national meetings for the last twenty years. In 1970-71, I was Chairman of a Task Force in a national group that was trying to design a model licensing code. We came up with what we thought were simple sensible

recommendations, one of which was not to require an entrance physical examination, but to have some kind of record of whether the child had ever been under the care of a health resource, what findings had been noted, what problems there seemed to be, and whether any provision was made for follow-up for problems which required treatment. Unfortunately, we could not convince everyone that such a simple provision could work. I don't mean you would want to throw away all physical examinations or all physicians, but I do mean that we should use them much more selectively.

One thing I consider extremely important is immunizations. We have a silly law in California which states that no immunization can be given except on medical premises; which means Health Department Clinics open from 2-4:00 p.m. on Friday afternoon for example, or physicians' offices (and physicians always charge an extra fee for giving the immunizations) or in clinics. Immunizations are so simple to give, and it is very easy to get someone, a public health nurse or a nurse practitioner or someone in the community, to come in and give them on site, not to take the child somewhere else. There is just no excuse for not having immunizations. We must begin to give them in the setting where the child is and make it easier for both child and parent in this way.

I will end by simply saying that I like physicians, I like nurse practitioners, I like people caring for people no matter where they are. We all have to work together -- no one person can be all things to all people. All of your, I am sure, know many sensitive and intuitive health professionals who have seen ways of helping in a more practical sense in this joint task of raising our nation's children. You also have seen many of the less sensitive who will probably continue to "tell people what to do." The truth is, there are no hard and fast guidelines for healthy day care. We must develop them as we go.

CURRICULUM FOR HEALTH IN EARLY CHILDHOOD EDUCATION

Ilene Lee
Durham Nursery School Association

Under the sponsorship of Fayetteville State University's Title XX Day Care Training Project Wanda Hunter and I planned a college level course for day care workers. The 48 hour course was conducted in 4-hour sessions meeting one afternoon a week for 12 weeks.

Rationale

We feel that day care staff members are in an excellent position for recognizing, referring and following up the earliest signs of problems in children's health and development. Furthermore, the day care staff's contact with families makes this group an ideal one to facilitate linkage between existing community health resources and families who could benefit from such services. A third reason for developing such a course is the day care staff members' interest in and committment to promoting the health of the children in their charge.

Goals

Our goals for the course were:

1) To define the role of the day care teacher in improving children's health;

2) To promote teachers' practice of preventive health care by developing those skills required to meet the health and safety needs arising in the day care setting; and

3) To develop teachers' skills in conducting appropriate Health Education activities with preschoolers.

In working towards these goals, we hoped teachers would develop an understanding of the factors which work together to create a sense of well being, of health, in young children. We also hoped they would gain confidence in their ability to make a significant contribution to children's health.

Curriculum[1]

We divided our course into the following 9 topics listed in the order they were presented: Normal Growth & Development, Illness (including treatment and prevention), First Aid, Safety, Nutrition, Mental Health, Child Abuse, and Day Care Health Policies. We were fortunate

[1]Although we designed our own curriculum, there are several sets of self-instructional materials that could be used by individual day care centers for in-service training.

to be able to enlist the help of various "resource people" in the area. The list of those who were able to share their experiences and expertise with the day care teachers in a very practical and down to earth manner included: Ann Royal, a nurse for the Fayetteville DEC, George Dudney from the Dental Health Section in Raleigh, local Red Cross instructors, Nancy Johnson from the Nutrition Section of Health Service in Raleigh, and Chip Modlin, the director of Cumberland County Department of Social Services. This group represented our conscious effort to have an interdisciplinary approach.

To supplement their contribution we used films and filmstrips available in the state. Let me mention here several of my favorites: the film, "Looking at Chidren" and the filmstrip, "Human Development-2-1/2 to Six Years" are excellent and available free of charge from Health Services' Film Library in Raleigh. Films can be ordered by calling (919) 733-3471. "How Our Bodies Fight Disease" and "War of the Eggs" (dealing with child abuse) are also available from the film library. We used another source of good filmstrips - Parents Magazine. Some of the sets that we found to be most effective are: "Food & Nutrition;" How an Average Child Behaves from Birth to Age 5;" "Day to Day with your Child;" "Child Abuse and Neglect;" and "Health and Safety". If your agency is unable to purchase a set, you may order it on 30 day approval basis, free of charge.

Every day care teacher in the course received a copy of 2 books which we used as texts. The old stand by, Your Child From One to Six is still useful and is excellent as introductory material. Furthermore, the book is available free of charge. Child Care from La Roche is newer, and more appealing graphically. Day care mothers and those working with infants found it especially helpful.

Training techniques we employed were influenced by the wide range of experience and knowledge among the participants in the course. To bring about attitudinal changes, we planned for much discussion between participants and with our resource people/consultants. Lectures were kept to a minimum. We also wanted the teachers to have active involvement in their learning and so we planned for small group work, role plays, demonstrations and student projects. One group of course participants arranged for vision and dental screening to be done at their center. Another group planned a spring parent meeting to share information about dealing with impetigo and other common illness. The presentations of these participant projects to the rest of the class helped maintain a supportive, cooperative feeling amont the participants as well as providing a lot of good practical ideas on activities the teachers could do with parents and children in their own centers.

What We Accomplished

The foremost accomplishment of the course was the teachers' acquisition of basic First Aid skills. Participants cited the Red Cross eight hour multi-media session as one of the most helpful parts of the course. Another result of the course was the reinforcement of the importance of a preventive approach to health care and the teachers role in this as health educator, facilitator in referrals, and provider of first aid and routine primary care for minor illnesses occurring in the center. Another accomplishment, which I think is important, is the broadened concept of "health" the teachers developed. In addition to the importance of first aid, safety rules and morning inspections they developed an appreciation of the influence dental care, mental health and coordination of community resources have on a child's state of health.

Evaluation, Recommendations, & Summary

1) Training for day care teachers in health issues should be more widely available. The need and the interest are both there.

2) Start at the beginning with those very practical skills of First Aid and taking temperatures, but do plan to build on that foundation with sessions on Nutrition, Dental Health, as well as Recognition, Treatment and Prevention of Disease. Plan enough time for discussions - 4 hours on each of the above topics would not be too much.

3) Link in with a variety of experts and health care providers. This lays the groundwork for further coordination of effort. Also, direct contact with other professionals increases the day care workers' sense of professionalism.

4) Don't hesitate to ask the various health providers for help in training the staff. They will appreciate your interest. Don't hesitate to offer your services for training and consultation. You will be well received. Have the expectation that day care staff members want to be part of the health team; they are willing and able and an excellent source of follow-up.

5) Extend these training activities to parents. This is something we could have emphasized more.

6) Use the excellent films that are available and get health resource books into the hands of teachers. Every center should have a copy of a basic First Aid book. An excellent new one is A Sigh of Relief.

Health Resources for Day Care Staff Training

Films and Filmstrips

Nutrition: "Jennie is a Good Thing" available from MTP (Modern Talking Pictures, 1889 8S South, Charlotte, N.C. 704-392-0381).

"Eat Drink and Be Wary" available from Educational Media Division, State Department of Public Instruction, Raleigh, N.C., (733-3193).

"Food and Nutrition", Parents' Magazine Films, Inc. Department C, 52 Vanderbilt Ave., N.Y., N.Y. 10017.

Growth and Development:

"Looking at Children," Film Library, Division of Health Services, Raleigh, N.C. (733-3471).

"Human Development 2-1/2 to 6 Years," Film Library Division of Health Services, Raleigh, N.C. (733-3471).

"How an Average Child Behaves from Birth to Age 5" and "Day to Day With Your Child," Parents' Magazine Films, Dept. C., 52 Vanderbilt Avenue, N.Y., N.Y. 10017.

Child Abuse:

"War of the Eggs," Film Library, Division of Health Services, Raleigh, N.C. (733-3471).

"Child Abuse and Neglect," Parents' Magazine Films, Inc., Dept. C., 52 Vanderbilt Avenue, N.Y., N.Y. 10017.

Childhood Illnesses:

"Health and Safety," Parents' Magazine Films, Dept. C., 52 Vanderbilt Avenue, N.Y., N.Y., 10017.

"How Our Bodies Fight Disease," Film Library Division of Health Services, Raleigh, N.C. (733-3471).

Reference Books

A Sign of Relief, Green. Available from Kaplan's School Supply, 600 Jonestown Road, Winston-Salem, N.C. 27103 (919-768-4450).

Child Care, Sutherland Associates, 8425 West Third Street, Los Angeles, California 90048 - $5.95.

The following are available FREE from H.E.W.:

Write to Mrs. Marie Byrd
Department of H.E.W.
330 C Street, S.W., Room G.311
Washington, D.C. 20201

Phone orders accepted. Call 202-245-1605.

Your Child from One to Six

Young Children and Accidents in the Home

Day Care #6 - Health Services, a Guide for Project Directors and Health Personnel.(DHEW publication No. (OCD) 73-12).

Health Curricula Useful for In-Service Workshops

C.D.A. Instructional Materials, Books 1 and 8, Texas Department of Community Affairs, Early Childhood Development Division, P. O. Box 13166, Capital Station, Austin, Texas 78711.

Early Childhood C.D.A. Learning Modules, Beaty and Minyard, Elmira College, Elmira, N.Y.

A DAY CARE CENTER'S APPROACH

Susan Russell
Community School for People Under Six, Chapel Hill

At the Community School for People Under Six our concern is the total care of a child, and we have certain theoretical feelings about what that is and whose responsibility that is. We believe it is the parents' responsibility and the parents' right. Health care is up to the parent. What we can do at the day care center is to help facilitate parents getting to appropriate health care. We don't feel we can take that responsibility away from parents, but we can make it easier for parents to meet their responsibilities.

We feel our minimal responsibility is to establish a health policy within our own center. There are three components to our health policy: 1) to insure children's rights, 2) to insure parent's rights, and 3) to protect our own center.

The first way we attempt to insure children's rights is to maintain up-to-date and thorough health, illness and immunization records. We've had kids with all types of health problems. The only way you can deal with that in a center is to know about those problems and to have adequate information about them. You need to know about a particular problem as it affects the individual child. It's also going to affect the center and you need to know what to do within the center to accomodate that problem.

The second way to insure children's rights is to maintain a well-trained staff who can perform early screening for both acute and chronic medical and behavioral problems. How do we do that? We try to locate health professionals in the community to come in and teach us, for example, about illness and how to deal with emergencies. We also attend workshops on health care. We have resources that have been collected through the years at our center, and we have people who have experience through the years of service in dealing with certain health problems and emergencies. So we teach each other how to deal with health problems within the center.

The third way to insure children's rights is to maintain a safe environment. We do systematic checks, as well as look at the total environment. You have to be concerned with the whole picture--become sensitive to it and to correct potentially dangerous situations. If you find that three particular children are not able to handle cars running up and down the room, then those children need to be directed into other activities, if that's going to help prevent accidents.

The fourth way to insure children's rights is to have clear-cut guidelines in determining whether or not a child should be in day

care. We ask ourselves three questions: 1) Is the child well enough to participate in the program? 2) Can the child give an illness to another child? and 3) Can the staff handle the illness or injury without extraordinary disruption? These three questions protect the individual child as well as all of the children.

The second component of our policy is protection of the parent's rights. The parent should assume it is his/her right to be given all information which the day care center has about a child's health. In an emergency situation the parents should be called first. In a situation where there's any question, the parents should be called first and allowed to make the decision. We don't feel it's right for parents to discover problems after the children have gone home. There are also the long-term problems that parents have to be informed about. For example, when we suspect a developmental problem that might take some time to assess, we need to sit down with the parent(s) and work out the direction that we're going to go to get a solution.

That kind of collaboration ties in with the center's rights. We feel that, if we give responsibility to the parent(s) then we have in essence covered ourselves. Sometimes though, we have to exert our own rights. For example, if we can no longer deal with a certain situation, we have to say to the parent, "Come and pick up your child." But rarely can we say, "You have to go to a doctor." We can sit down and talk to the parent about why we think they should go for health care, but we can't make them go. We can suggest various available resources; and we try to make getting to those resources as easy as possible. We often take the kids ourselves, if that's what the parent wants. Or we try to set up times during an evening or weekend so that parents don't miss a lot of time from work. It's only in situations where the center's security, or the children's security is jeopardized, that we say that you can't come back until you have been seen by a professional. Those are some of the things that go into setting a health policy.

In addition to the rights of parents, children and the day care center, three things are happening in our center that we hope most centers are doing. The first is health education. A day care center is a perfect setting for teaching parents about the health of young children. We try to make handouts available to parents, like one called "Guidelines for Sick Children." We use our bulletin board to put up information about health problems. We have books that we lend parents about health care. Health education for children is just as important as for the parents. We see two components of that process. First, it is very important to teach children about their bodies and about health care. For example, we have a dental hygienist from the health department who comes in and teaches the kids about "Mr. Plaque" and the kids love it. The other component deals with helping kids be more aware of their feelings about their own bodies and health problems, as well as about other people's. A day care center provides the perfect

opportunity to begin teaching acceptance of others who have various health problems.

The second important activity is organizing a support system for the center and for parents. If you have isolated a problem, you need a place that you can recommend or suggest that a parent go. We never tell a parent about a problem without offering a direction to go for help. We try to make it as easy as possible for parents to follow through with their responsibility. Then we check back with them, and if needed, offer our services to get the kids to treatment.

The third activity is setting up a free screening clinic. We've tried to have a broad focus on screening, and so we cover about eight different areas. They include developmental, behavioral, dental, speech and hearing, visual, medical, nutritional, and environmental.

This philosophy and these activities make up one day care center's approach.

THE ROLE OF THE CONSULTING PHYSICIAN

Jean Sharpe
Orange-Chatham Comprehensive Health Services, Inc.

I think the role of the consulting physician should be expanded. People who are consulting physicians should be doing a lot of different things other than the standard things doctors are usually thought of doing. At the same time, I feel the role of the consulting physician should be limited. The key words for us in a lot of ways are self-sufficiency and self-help. It's important to talk about health needs and not medical needs. Health does not equal medical care.

I'd like to look for just a minute at that title: "The role of the consulting physician." I think I'd like to modify that. It should be "The role of the consulting health care provider." Physicians certainly can have a role. Use them as best you can; get their cooperation and support. However, here we're talking about physicians, nurse practioners, day care staff, audiologists, health nurses, dental hygienists. All those poeple are going to be consulting health care providers for your day care centers. I think in many situations, the physician may be the least central of those.

Who does have the most important role in the health care of the child? On one level, it is the children themselves who have the most important role. After that, it's the parents. After that, in our situation, it's the day care staff. So that the nurse, the doctor, the health care professional really are pretty far down the line in terms of that child's day to day health and health care. The health care provider is a consultant. Again, seen from my point of view, the day care staff and the center are acting as a real major source of health care for the children and the whole family. The physician's role (and other health care providers) then should be that of 1) sharing information, and 2) promoting development of the staff and the family in their abilities to care for and to support the child's health and to understand and take care of their own health needs. Most people take very good care of themselves (given a certain amount of support and information) and know when to use physicians and health care providers wisely.

My consulting experience has been with a day care staff that sees themselves as a health resource and really agressively works to provide that role for families and works for family involvement. I'd re-emphasize things that have been stated about the role of the day care staff and setting of policies. A day care staff uses policies as guidelines in deciding such things as whether a kid can stay at the center, and how parents can manage certain common illnesses. These are things we worked on together with the staff of the center I have consulted with.

This has involved meeting with the staff, sitting down and going over points and writing guidelines and a letter to parents.

What about the role of that consulting health care provider? There are several ways that I think health professionals can provide supportive services to a day care center and staff. One, certainly the most standard, is as a direct provider of services. I agree completely with our first speaker this morning about the value of those pre-screening exams. In terms of that physical exam, there are many other aspects of screening (the vision, the hearing, speech, and so on) that are far more likely to give you some results. But that standard medical exam, I agree, generally doesn't do very much except possibly get the parent in contact with a health provider who can ask other questions. However, there are laws that say you must have that exam, so whether or not it's important at this point it must be done. That's certainly a service doctors and nurses have to provide. Professionals will do things for children they won't do for other people. As a group, pediatricians tend to be community-oriented and likely to respond to a request to donate time, to go out of their way to do things and to act as emergency consultants. The nurse or doctor who is available to you on the phone provides an important service.

The most important way physicians and nurses should provide consulting is in terms of staff training. Information is one level of training. Attitudes towards children's health is a more important level of training. This is a little hard to get at because it depends on a lot of the attitudes of the professional you've got helping to do training. It's really critical for the staff to be very clear about differences in children and about their attitudes towards those differences. The staff really need to be keyed into that so that they don't find themselves discriminating against children on the basis of things that are racial, social class, or cultural differences.

Consulting health providers could be involved in helping build up libraries of resources and of hand-outs. Audiovisual diagrams, resources to use in explaining things to children and staff -- these are things that I think you can ask for.

Parent and child training is really a key. Health care consultants should have evening training sessions with parents about health and go through some of the same things that are done with the staff.

I think the health care provider (and this is something you can't make somebody be) should be a real advocate within your community -- for day care, for health, and for children. I think health care providers should be very political, they should be standing up with you, with other agencies, with your county commissioners, your people who are trying to get money.

In closing, I just have to put in my own philosophy about what the role of a health care professional is. The role of the physician is to support the body while it heals itself. That's a real philosophy we should come to understand. Not that there's no place for medicine, not that we should go back 100 years and throw out hospitals, medicine, medical exams; but all that has to be in perspective. The role of any health care person is not to cure every ill, stop every pain, stomp out every fever; but to understand that process, to have the information -- when to worry, when not to worry -- to share that with parents and with children, and to help teach families and children to take care of themselves. We must see our role as supporting and helping and not always intervening and doing.

UTILIZING A FAMILY OR PEDIATRIC NURSE PRACTITIONER

Beth Broome Hammond [1]
Atlanta, Georgia

When I first came to Buncombe County as a nurse practitioner, we had a dilemma. The state does require by law physical exams on the children, and that took priority over any other health activity -- we were running neck and neck to get the physicals done.

I'd like to give you a brief summary of what I did during the year that I was there. The first thing, because there had been no previous health care provider in the system, was to set up a record system: develop the physical form, history forms, a way to keep notes on the children and the problems. We set up workshops on pediatric emergencies which I conducted. We made little booklets for the day care homes and day care centers on treatments of nose bleeds, bee stings, on the common things that happen with children. I did developmental screening, using the Denver Developmental Screening Test. Developmental delays were found to be the biggest health problem with our children. I taught the day care staff to do the developmental screening, and we had workshops on how to be more in tune to developmental delays and how to recognize them. We had a speech pathologist and she and I together did hearing screening on all the children.

Treating minor illnesses such as rashes, and referring minor illnesses was a big part of my work. We had to get permission to have a child seen by a physician, but we usually did the minor treatment. The minor emergencies were treated there and then I talked with the parents after their day was over. Referrals were made -- many referrals. I had consultation, a pediatrician preceptor that I could call at any time for my multitude of questions and that I could take children to at any time. We made referrals to Developmental Evaluation Centers, the Mental Health Centers, and various agencies within Buncombe County. In addition to the physical, I started collecting histories with the parents. This was done in the afternoons when the parents would come to pick up their children.

We held parent consultations from time to time. We held them to discuss different individual child health needs that the parents and the centers could work on together. Physician consultations on the various children were held mainly with my pediatrician preceptor.

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[1] Beth Broone Hammond worked with a Federally-sponsored child care program which included 8 day care centers and 4 day care homes, serving approximately 280 children in Buncombe County, North Carolina.

This was a mere glance at the role of a nurse practitioner in Buncombe County. The position was funded for one year, and that is not long enough to adequately serve the health needs of children, when you've got 280 plus the new children that came in. There are physicals to be done so day care can stay in operation because that's a state law. That took priority; that took a lot of time. Things that would have been excellent would have been more parent classes, night classes for the parents on child health, child rearing practices, developmental stimulation, diets for growth and development, activities for the parents to get them more active. That active level of the parent needs to be done. Other recommendations are for the history part that I had so much problem with. I suggest forms with basic layman's terms and questions for parents that can be picked up at the center and brought back and can be transferred to a regular history form. I would also recommend more child health classes. I conducted a few of these with the five year olds at some of the centers -- child care, cleanliness, taking care of your teeth, this type of thing.

This was my first job. Experience, I believe, is important in doing a thorough job and recognizing the health needs of children. I feel that I did provide health care for these children to the best of my ability at this time, but I would love five years from now to have the job I just finished.

ROLE PLAY: Divergent Expectations of Day Care Providers and Health Personnel

Becky Williams
Land-of-the-Sky Regional Council

Alise Irwin
Buncombe County Health Department

This small group session began with role playing of a problematic interaction between a day care professional and a health professional. The dramatization was followed by a group discussion.

Role Play Situation

A day care center has a sick child with a high fever who is vomiting. The day care director called the public health nurse, twice. As it was 4:45 p.m. the nurse refused to go out to the center. The director could not contact the parents. The nurse recommended that the child be taken to the emergency room.

Issues Brought Out in Discussion

1) The center should have the telephone number of another responsible person to be reached in case of emergency.

2) The nurse didn't come because nurses can't provide treatment such as the child needed.

3) Is there a "correct" use of the public health department?

4) An agreement might be set up between the center and health department regarding the kinds of services the center will and will not receive.

   a. Should the role of the health department be prevention and education rather than treatment?

   b. What procedures and criteria should be used for decision making around health issues? How shall these procedures be created?

5) The center should have emergency procedures developed in the event parents or other emergency contacts cannot be reached. Who should develop the procedure?

6) Parents should be informed, as soon as possible, about any illness or injury and what treatment procedure (if any) has occurred.

7) Day care centers need to have a health professional available for telephone consultation regarding such issues as: tick bites, treatment of a fever or other minor illness.

8) Should sick children be excluded from normal day care activities? A person from the Frank Porter Graham Child Development Center reported that sick children may participate in the activities as long as the child feels he/she wants to. Their studies have shown that there is no real reason to exclude children with minor illnesses.

9) Day care personnel want reassurance and practical suggestions. Where can they get this? From: a) private pediatricians, b) public health departments, c) by entering into an agreement between the health department and the day care center, and d) by getting assistance from health personnel in writing reasonable health policies for the center or day care home. Reassurance that the day care worker has done, or is doing, the "right" thing for the child is a significant need. Support for necessary common sense actions appears to be the greatest lack among day care workers.

DEVELOPMENTAL LAG: How to Recognize It and What to Do About It

Carol Gestwicki
Central Piedmont Community College

There are two very important cautions about developmental lag. The first caution is not to over-react and the second one is not to under-react. If the child is getting behind in development, there are certain factors that may be able to change that.

Now when we're talking about development lag, we mean a deviation from normal. But normal has very wide limits. It's important to realize that a lag may be in just one or in all areas. But what we usually find is that because all aspects in a child are knit together, a lag in one area is liable to eventually lead to a lag in other areas.

Basically if we have a sound, genetic endowment for a child, plus a favorable environment, a child is going to follow a certain predictable pattern in all areas. But many normal children lag behind their genetic potential because of detrimental environmental conditions encountered at some time. Prematurity, viruses, and drugs are all factors in the prenatal environment which could lead towards developmental lag. Factors in the environment after birth can also influence developmental lag. We know some illnesses will cause development to slow down in all areas. Then there are factors in the environment which have nothing to do with physical causes. These include patterns of the cultural environment in which the child is living, the effects of malnutrition that might be associated with poverty, or the experience of growing up in a hostile emotional climate. These are very complex factors which may cause any given child to lag behind normal limits of development at any one point.

A normal child will go through a predictable pattern of development and that's a pattern that gives us an advantage in observing children. A pattern is not a time table. Once a child has set his own rate of moving through his predictable pattern, he tends to stick to his own rate. So if we see a real change in a child's rate of development, there is a place for us to start observing with care.

How do we know a lag when we do see it? One of the most useful concepts for helping us deal with this may be the idea of critical periods. There are certain periods which are most critical for acquiring or developing a new skill. After the child moves past this critical period, he will never again develop this skill with quite the east that he could during the critical period. For example, the most critical period for total physical growth is in the first year. If the lag begins at this point, it is quite probable that that lag will continue.

We may still have lagging physical growth in height and weight, even with very adequate nutrition in that first year if the child has not been receiving what he needed emotionally to go along with it. Whenever we see developmental lag one of the first things that needs to be investigated is a possible physical problem. After that area has been explored and the answer found, we then start looking at other factors in the environment.

Now I'm going to list some land marks that we would be expecting a child to achieve at a certain point. If he weren't then the warning signals about developmental lag should go off in our minds. With young infants, say from 4 to 16 weeks, we're talking about a child who should be moving from random reflex movements to more purposeful motor behavior. I would be very concerned during this period if I saw a child who didn't look at objects, if I saw a child who didn't respond to sound, to voice sounds particularly because that's the beginning of language development. I'd be concerned if I saw a child who didn't grasp objects during this period. I'd be very concerned if I saw a child who didn't lift his head when he was lying down flat on his belly or who didn't balance his head when I was holding him and sitting him on my lap. And then the last thing that I'd be watching for would be whether he'd smile in this period.

By the time he gets to about 40 or 48 weeks, I'd be concerned if he wasn't showing some attempt to sit without support. I'd also be concerned if he wasn't using his thumb and index finger together like little pinchers. I'd be concerned if he got to between 12 to 18 months and he wasn't making any attempt to stand without support, and making some attempt to move, as well. If I had a toddler between a year and a half and two and a half not walking or eating independently and not drinking from a cup, I would again be concerned.

In early childhood (the period from about 2-1/2 up to 6) I'd be looking most at his motor coordination. The thing that we need to be seeing at this point is ability to do activities which require balance. These activities tell us something about the way the brain is developing.

There's another critical period that I would be aware of. This is a period back during the first six months for what we call attachment - becoming attached to another human being in a relationship. To show this attachment, somewhere around 6 to 10 months the baby normally starts to turn away, or even may scream, when strangers come around. At the same time he starts to show stranger anxiety, he shows separation anxiety when the person to whom he's gotten very attached leaves the room. How long should this stranger anxiety keep going on? It usually peaks at around 8 months and then peaks again at around 18 months. If we see it long after age two, then we have some reason for concern.

Let me talk a little about language, as I believe it may be the one area many of our children are lagging behind in. The critical period for language development is in the first two years of life. The very first thing that we see in a normal infant between 3 to 5 months, is babbling. By the time he's between 6 to 8 months of age, he's also doing a lot of social babbling, where he babbles to you and you talk back to him. By the time a child has reached the age of one year, I shouldn't necessarily hear real words, because the average child may not say more than one, but the child should be understanding the meaning of the words that I say to him. All the way through the early childhood years this receptive language should be way ahead of his spoken language. If he's not receiving language and understanding it by the age of a year, he's lagging behind in language development. During the second year he should be starting to produce speech of his own if only a few words. By the time a child is two, if language development is normal, I expect that he is using speech -- usually what we call telegraphic speech, where he just says the important words like you would if you were sending a telegram. It takes up until about age four before we've really got all the sounds coming through accurately. A good guideline to keep in mind is, if I've got a four year old and a stranger can walk in the room and understand about 80 or 90% of what that child says, he's got normal language.

Another area of concern is independence. There's a critical period for developing independence in a young child that comes soon after he stands and enters toddlerhood. It is at this point that we need to begin to give responsibility to the child in areas of feeding and doing what he can for himself. A child whose first attempts towards independence are stomped on may become the child who at the age of 6 is timid and passive and terrified.

Let me mention two other areas. For cognitive development during the early childhood years we want the child to be developing a positive attitude toward learning, a drive toward curiosity. Here again the critical period for helping a child see that he can make discoveries, and that he can learn about his world and himself, through his own activity, is back in toddlerhood. If we see a child who is not making those kinds of discoveries as he moves along at 3 and after then we've got a child who's knowledge and learning abilities have lagged behind. Now let's just talk about social development. I'd be concerned about a lag in this if I saw that, week after week, a child over the age of three resisted any separation from his care giver, from his parent. If he plays near other kids but doesn't really want to interact with them, I'm worried. I'm worried also if he continually disrupts other children's play - and fails to do anything that would attract other children to him in a positive way.

What if we are concerned about developmental lag. What if you see any of the kinds of things that we've been talking about here. My

first consideration would be that I want to get all the facts I can about this child, and I would start making a lot of detailed notes and observations. There are good developmental tools that we can also use to assess where a child isn't developing. One is the Denver Developmental Screening Test, though I'd want to make sure that I was writing down some anecdotal observations, too. The next thing to consider is building the kind of parent-child relationship which turns parents into effective teachers. Many of the things that we mentioned, are the things that are affected by environment which the parents may be able to control. If we can help parents understand what's normal in development and what children need at different ages, we will be on the way to helping prevent developmental lag.

HOW TO USE A MEDICAL RECORD

Selma Deitch
Chairman, APHA Committee on Child Development

Previous speakers today have indicated that the medical record is of little or no use to the day care staff in their efforts to understand a child. My experience has been that the medical record can be of great help when filled out completely and accurately and if used together with observations made by the day care staff. Even the one-page form published as a sample by the North Carolina Office of Child Day Care Licensing can be used by staff and families. When the form is not filled out properly, it should be the responsibility of the day care program and parents to confront the health provider for more complete information and if not successful, to seek another health resource.

In a preschool day care program we should be looking to the medical record for information regarding a child's current state of biological development as shown by such indicators as physical measurement, body proportions, neurological maturity, and physical strength. A well-presented chronological account of a child's physical development should also be included.

The more traditional but important information to have has been: 1) a report of the presence or absence of disease, 2) a chronological account of illnesses and hospitalizations, 3) the immunization status for recommended protection against communicable diseases, and increasingly 4) reports of screening for anemia, lead poisoning, vision and hearing. The medical record should be of help to the day care staff in promoting a child's capacities and preventing child functional disorders, many of which may be the result of poor understanding of the whole child and unrealistic performance expectations. We see functional disorders in such forms as hyperactivity, inattentiveness and unacceptable behavior in group activities.

Of great help to the day care program is the physician's assessment as it relates to biological maturity, rather than chronological age of the preschool child, and the explanation of any irregularities or inconsistencies if they do exist.

We know that physical growth takes place in a predictable sequence, that the rate is specific to the individual, that there are wide variations from one individual to the other, and that growth is affected by environmental factors such as nutrition, diesase, and pollutants.

Most preschool staffs base their daily plans on the expected capacity of the group, and most groups are made up of children of the same chronological age or a range of ages with age-related expectations. When a child is registered for a program, the medical record should help identify the uniqueness of the child's development. Sometimes this is done well and is used by a day care program; sometimes it is there and tucked away in the folder; sometimes it is there in a form that is not understood by the staff; and much of the time it isn't recorded on the form at all.

Day care staff have their own expertise in assessing a child. The child functional assessment for this workshop was prepared by a day care staff person in the community where I work. She began by describing objectively the overt indicators of a specific child's maturity on the basis of both physical and social attributes as well as the child's adaptive capacity. Following this she determined that the child is functioning solidly as a mid-preschooler but shows some irregularities in her motor functioning -- particularly gross motor functioning. It is then noted that the child being described is five years old and will be expected to go to public school in the fall. The day care program in which this child is enrolled has been able to respond in a promotional way to her areas of high performance -- social interactions -- it is felt, however, that her motor development as seen in her management of self-care and tasks, requires further investigation.

Does the health history help? Yes. We learn that this child was born prematurely to a diabetic mother; that she had respiratory distress following her birth and remained in the hospital for one month. The possible lack of circulating oxygen at this critical time of rapid growth of the central nervous system should be considered an "insult" that could be related to later developmental problems. At 18 months of age she had a convulsion and remained on phenobarbital for 1 1/2 years. She has had intermittent attacks of asthma.

Does the current medical exam help? It should. Even using the brief form provided by the NC Office of Child Day Care Licensing, we see checked off the mother's diabetes, the prematurity, the respiratory distress, and the convulsion. We also see that immunizations are up to date, and vision and hearing were found to be normal.

The child's height and weight were recorded at the time of the exam and they both fall below the third percentile if plotted on a growth chart. This is not mentioned on the medical exam form, but should at least provoke the physician to indicate how he explains her small stature and low weight and whether they warrant further investigation. The organs are all checked off as OK and the Impression is, "active, alert child."

This should not be an indictment of the medical form, but of the physician. The observations made by the day care staff should have been noted also in the clinical exam and explained (even if further investigation is not indicated or treatment is unnecessary). Without acknowledgement of this irregularity in physical size and motor coordination, the next environment may not respect this child's understanding of her own problem when she asks for help or does not participate in selected activities. The classroom teacher may well say, "You're five years old and you should be able to get down to the basement by yourself." or "You can do better than that," in some recreational activity or in writing. Reference to the medical form will support this interpretation and our preschooler will no doubt develop a functional disorder. In her case she will probably withdraw, associate less with her peers, participate less and less in acitivities next year with school performance the next area where she will be unable to achieve.

Day care programs, with health consultation must support families in getting the best assessments from their health providers. The day care and family descritpions of the physical and social characteristics of the child should be shared with the physician. A staff person could help in writing a clear letter, making a telephone call, or actually making a visit to the physician's office to make sure the information recorded at the program is read and understood. Then a reassessment of the child by the physician should be made. Every effort should be made not to interrupt what is good about the relationship of the family with their physician. If this is unsuccessful, however, another physician or clinic should be suggested to the family.

The medical service can be responsive to the needs of families and staff of institutions caring for children to prevent the development of functional disorders created by poor understanding of the uniqueness of the child. The medical/health record should describe the results of the exam and its implications explained in terms that can be understood primarily by the parent and preschool staff.

WHO OWNS THE CHILD?

Rutherford Turnbull
Institute of Government, UNC-CH

The issue of who owns the child in the context of your work, I think, could be addressed by talking about 1) the law and the general "rules of ownership" of, if you will, the child; 2) the exceptions to the general rules, and then 3) the procedures that day care providers ought to follow with respect to working with the parents of children.

It was not until somewhere in the early part of the 20th century that you begin to get a view that the public had a right to intervene in the decisions that the family makes with respect to the child. Now the view that the state (the public) has a right to intervene in the family life rests on a traditional view of law called *parens patriae*, which is a law term that expresses the view that the public, or the state, is the father of dependent persons and therefore is entitled to intervene in their lives. This is the justification for the exceptions that we have to the general rule that the child belongs to the parent; the exceptions being the rules that justify or express the view that the state may intervene in order to do something in behalf of the dependent child when that child is not being properly cared for or cannot be cared for by the parent. Even today, despite the Children's Defense Fund, despite the Supreme Court, despite a lot of the current thinking among some people, the view that the child belongs to the family is still the general rule. There have been some very major exceptions to it, however.

Let me show you some illustrations of how today we say that the child belongs to the parents. Who has the power to consent for the child being placed in a state hospital, state mental retardation centers, public hospitals for medical treatment, into schools? Who has the power to decide whether to withdraw the child from schools? Who has the power to decide what religion the child will be brought up in? Who has the power to decide with respect to whether the child does any number of things? Well, the answer is: the family decides.

In North Carolina there are essentially two exceptions to the rule that the child belongs to the family. The first exception deals with medical care for the child. The second exception deals with the abused and neglected child. When you're talking about day care, you are now talking about children so young that the only way to protect them "against their parents," as it were, is to create statutory exceptions to the general rule that the parent controls, and to write those exceptions into law.

Let's talk about medical care to begin with. The normal rule in North Carolina is that minors on their own cannot consent to medical treatment. Who can? Well, the parents can. Why? Because the minor does not have the mental capacity to make a decision about whether he should get medical care. That being the case, you cannot have medical treatment for a child, as a general rule, without parental consent because that is consistent with the common law view that the child belongs to the family and that the state may not intervene. There are going to be situations, however, when the child is in an emergency situation and then, and basically only then, may the child be given medical treatment without prior parent approval. In any one of the following situations, a physician may lawfully treat the child without parent consent: 1) the parent, or parents, or the guardian, or the person *in locl parentis* cannot be located or contacted with reasonable diligence, when the minor needs to receive treatment; or 2) you don't know who the minor is, or the need for immediate treatment is so apparent that any effort to secure approval would delay the treatment so long as to endanger the child's life; or 3) an effort to locate the parents, guardian or person *in locl parentis* would result in a delay that would seriously worsen the patient's physical condition. There is a 4th exception-- when parents have refused permission but the minor's life or physical condition would be seriously endangered if treatment were delayed long enough to obtain a court order. No treatment may be given in this situation without the opinion of a second physician that the treatment is necessary to prevent immediate harm to the child. (When the parents have refused consent and a second physician says it is not an emergency, no treatment may be given.)

Now how are you going to act in these situations in a day care center? My child Amy is swinging on the swings at the day care center in Chapel Hill and we just finished parent work day. While I'm working I don't put the screw in the bars that hold the swings properly and Amy comes tumbling down. She breaks a leg. Now what do you do? You can't reach me because I've gone out for coffee and doughnuts for the mid-day break. You can't reach my wife because she's taken the phone off the hook in order to nurse the baby and there's nobody else around as guardian or *in loco parentis* to Amy. What do you do? Well, you use the 3 emergency situations. You take the child to the emergency ward at Memorial Hospital, give your name, and say that you are from a particular day care center. You don't have to worry about consent for treatment. That's the neat thing about the emergency rule because consent is implied. You need to know about the emergency treatment rule. Most physicians know about it. Most hospital emergency rooms know about it, but you need to know about it as well so that if you get down to a situation of persuading the doctor to treat, it gives you some help.

What about emergency treatment by individuals who are responsible for the child at the time? For example, In cases where you get breathing problems that have to be dealt with. You go ahead and do it. Now why can you do that? Well, first of all you're not going to be held to the same standard as a physician because you're not a physician. The standard of care is lower. You're just acting as an ordinary person. Parent consent is going to always be implied in those situations. So the law as a matter of policy protects the child while it implies the consent. Also, I bet you've got in your files a parent authorization or parent consent form on each child so you don't even have to argue the implied consent. You have, we hope, good expressed consent.

Let's move from the medical situation to the law about child neglect and abuse. The *parens patriae* theory comes into play with abused children because the law is trying to protect the child who is dependent because of his minority and who is, in addition, being abused or neglected. The theory is that we are "taking away" the parents right of control over that child because something is going on that injures the defenseless child. The child abuse statute applies to a whole list of professionals, including physicians, social workers, mental health workers, public health workers, and the staff of a licensed day care facility. Those and other professionals are required by the statute to report suspected cases of child abuse or neglect. Then the statute says that any other person who knows of a case of child abuse must also file a report. The statute defines as an abused child a person under the age of 18 whose parents, or other persons responsible for their care, do one of the following three things: 1) they inflict, or permit to be inflicted, upon the child a physical injury by non-accidental means that causes or creates a substantial risk of death, disfigurement, impairment of physical health or loss or impairment of the function of any bodily organ; 2) they create, or allow to be created, a substantial risk of physical injury to a child by non-accidental means that would be likely to cause death, disfigurement, impairment of physical health or loss and impairment of the function of any bodily organ; and 3) they comit, or allow to be committed, any illegal sex act upon the child. There is also a definition of child neglect (and it's different from abuse). Neglect of a child occurs when the child 1) does not receive proper care, supervision or discipline from the parent or the care taker; 2) is abandoned; 3) is not provided necessary medical care; 4) lives in an environment injurious to his welfare; or 5) has been placed for adoption or care in violation of law, in other words, the "black market". The neglect definitions that are in the statute leave it wide open for you to disagree with the parent about whether the child is neglected. For example, what in the world is "proper care?"

Now, the report of child abuse must be made to the local Department of Social Services. The report may be made in writing,

orally, or by telephone. It must include the child's name, address, age, location, name and address of the parents and the type of abuse or neglect that is known or suspected. When the DSS receives the report it must investigate the situation promptly and it must tell the person filing the report the results of the investigation within 48 hours, two working days, after the investigation has begun. If Social Services determines that it's dangerous to report back to the original reporter, or dangerous to the child, no report back must be made. Now having a reported case of abuse or neglect, DSS will then do one of three things: 1) investigate and say nothing is to be done; 2) investigate and try to intervene through negotiation, intervention, or remediation; or 3) file a petition with the district court alleging that the child is neglected or abused and asking for a certain release. If the report is filed with the district court, a hearing will be held and the district court will determine if the child is abused or neglected. The remedies available to the district court are wide-ranging. I really think that for you the important thing is to know that abuse is not neglect and neglect is not abuse. There are different standards for each of those behaviors. The statute requires you to file the report with DSS. DSS will normally treat the information confidentially and the person who files the report may not be sued in criminal or in civil manners by the parents or by anybody else. In other words you are immune from civil or criminal liability for filing that report. The penalty for not filing it is not specified by the statute.

I want to conclude by saying something more about consent forms. General rule: the child belongs to the parent. If you have a medical emergency situation, there is no need for consent because consent is implied. If you have a neglect or abuse situation, consent is irrelevant because we are protecting the child against the very people who would have to give consent for treatment. That means the consent form has a very limited use. It does not apply to emergency, does not apply to an abuser, what does it apply to? Well, it applies to almost anything else that the day care center does with respect to the child. What kinds of things do you need consent for? The things you normally do with a kid during the time that they're in day care. Get consent for the usual thing that you do. You can have a consent form that says, "I consent to the activities described below, or described on the attached sheet of paper, because those are the general activities of the XYZ day care center." Just spell out what you would normally do. What if you want to take them to the movies? What about the movies or a bus ride or trip to the beach or the municipal swimming pool? If you're doing something that is a typical activity, and if there is any possible risk, that's what you want to get consent for. It's not that hard to do and it protects you like nothing else -- except good care.

HOW CAN LOCAL RESOURCES BE IDENTIFIED AND USED?

Katherine Nuckolls — Mountain AHEC
Jane Fox — Charlotte AHEC
Virginia Tate — Eastern AHEC
Barbara McGrath — Fayetteville AHEC
Betty Erlandson — Greensboro AHEC
Evelyn Jernigan & Margaret Pollard — Wake AHEC
Marjorie Anderson — Northwest AHEC

Each of the nine Area Health Education Centers in North Carolina were represented among the seven discussion groups. These groups met to discuss and exchange information in several areas. Reporters in each group recorded the major points. A composite outline of these points follows:

I. Local Resources Already in Frequent Use

- A. Local public health departments (mentioned most often)
- B. Area mental health centers
- C. County departments of social services
- D. Local day care or child development centers
- E. Parents
- F. Community colleges or universities
  1. student nurses used to do screening
  2. student nurses & instructors provide staff development materials
- G. State day care training projects
- H. Developmental evaluation clinics
- I. Private pediatricians
- J. Hospital emergency rooms
- K. Community health centers

II. Local Resources Available But Not Frequently Used

- A. Public health nurses
  1. to provide direct & follow-up services
  2. to help write day care health policies
- B. Headstart health and child development personnel
- C. State sanitation office
- D. State library in Raleigh
  1. audio-visual materials
  2. books and printed material
- E. Civic groups, such as the Lions' Club, for vision screening
- F. Professional mental health & medical organizations
- G. Preventive dentistry programs, e.g. "Swish-n-Spit"
- H. Health education libraries at hospitals & medical schools
- I. Area health education centers
- J. Red Cross, especially for first aid instruction
- K. County agriculture extension agents for nutrition education
- L. Mental Health's Early Intervention Projects for behavioral, emotional, or psychological guidance and/or assessment

III. Potential Resources Which Should Be Developed

A. Health education programs based on goals and needs of day care or child development programs
B. Health education team in local health departments
C. Health care workers with day care responsibilities

1. the need for such service should be documented
2. might need to realistically approach the director of of the local health department

D. Student nurses
E. Volunteer service agency or bureau

1. medical personnel should be approached about donating time through such a coordinated effort
2. could be a resource for sources of vision, hearing, dental, speech, mental & physical health screening

IV. Barriers To Day Care - Health Cooperation in Delivery of Service

A. Absence of communication

1. no understanding between day care & health providers about what each can & cannot do
2. efforts are not coordinated

B. Day care operations seem reluctant to use public health departments
C. Health department regulations

1. some require parents to accompany child to appointments
2. appointments are scheduled in blocks or times inconvenient to working parents
3. categorical eligibility and requirements to document need for service

D. Availability of transportation
E. Cost
F. Public health nurses have very limited time available for teaching
G. Efforts toward service delivery are fragmented among many different kinds
H. Health people's top priority is not day care and day care people's top priority is not health
I. Medical education does not include understanding community needs

V. Positive Action That Might Help Overcome Barriers to Cooperation in the Delivery of Service

A. Improve communication

1. agencies should talk to one another about needs and capabilities
2. find better ways to work with parents

a. workshops sponsored jointly by DSS & Public Health
b. one-to-one home visits
c. acceptance of individual life-styles
d. help parents voice needs

B. Disseminate more information on what's available through the Area Health Education Centers
C. Involve health professionals in day care as part of their education
D. Develop a central referral system for all services or a services clearning house
E. Become politically active

1. lobby for needs
2. develop political "clout"
3. make county commissioners aware of needs and problems, especially in financial areas

VI. Other Good Ideas

A. Develop a director of voluntary resources and health resources

1. United Way in Greensboro distributes a list of agencies to help children
2. civic group may be able to help

B. Each child in day care might have a card for running health record and for easy reference

HEALTH AND DAY CARE IN NORTH CAROLINA

Sara Morrow
Secretary, NC Department of Human Resources

I'm pleased to join you today as you wrap-up your day long session on Health Needs of Children in Day Care. You couldn't have asked me to come and talk about a better combination topics. They represent two major priority areas in this administration and for the Department of Human Resources.

Governor Hunt said it best when he committed his administration to children: "What we must do is put our emphasis on preventing those things that keep human beings from being all they can be. We have to literally raise up new generations that are free from disease and handicap."

The Department of Human Resources is committed to the belief that all children have a basic right to be born healthy.

How is the Department of Human Resources implementing this concern for children?

A. By establishing the office of the Assistant Secretary for Children.

B. Through identification of high risk mothers and infants. We know what the risk factors are. The more we can catch problems or potential problems early and do something about them, the better off we are. For a healthy mother has a better chance of having a healthy child. We have moved screening back from four years of age to infancy. Ninty-nine percent of our infants are born in hospitals, and it is here that the public health nurse can pick up high risk babies and get them into the system.

C. However, there is a need to provide a continuation of care, for some problems develop later.

1. Proper nutrition is crucial to keep children healthy. Programs such as WIC & Food Stamps help to do this.

2. Immunizations are vital.

3. Child Abuse: The new reporting law is important, and day care providers can assist in carrying it out.

Prime objectives for your county health department are prevention of disease and promotion of health. The North Carolina Department of Human Resources is cutting across division lines. This needs to be done at the local level also.

Health Education

We are all educators and one vital area is health education. Lack of knowledge is a major reason people do not take responsibility for their own health. It is a sad fact that of the $120 billion spent each year on health, only between 2 and 2 1/2 percent is spent on disease prevention and control measures and only 0.5 percent on health education. But prevention and education efforts can have the greatest impact on improved health. In 1976 a new national health information and health promotion act was signed into law. It is designed to encourage healthier living habits and puts emphasis on the federal government's role in disease prevention control. And we all know that starting is important. Children can be reached and it's their attitudes, knowledge and habits that will have the biggest impact on their health. I support increased funding of health education in our schools which stresses what people can do for their own health. I was disappointed the NC House Bill 540, which would have established a statewide School Health Education Program, did not pass in the last legislative session. The medical auxiliary also supported this bill. It will be coming up again and I urge you to follow it and support it.

Day Care

We estimate there are 172,000 children who need or could benefit from good day care. There are 82,000 day care slots across the state. We need more day care than the average working family can afford. Day care that goes beyond "baby sitting," and is responsible and responsive to the developmental needs of the child. One way to make day care more affordable for the average family is to tap into existing services in the local health department, social services department, etc. A proposal for a comprehensive day care program for North Carolina will be coming out of my office the end of June.

George Herbert Tinley Kimble in his book, "Tropical Africa," sorted out the priorities well, I thought, when he wrote:

"It is hard enough that a man should be ignorant, for this cuts him off from the commerce of other men's minds. It is perhaps worse that a man should be poor, for this condemns him to a life of stint and scheming in which there is no time for dreams and respite from weariness. But what is purely worse is that a man should be unwell, for this prevents his doing anything much either about his poverty or his ignorance."